

**Customer Agreement
Automatic Funds Transfer
Authorization Monthly
Payment Program**

P.O. Box 91120
MS 295
Seattle, WA 98111-9220



SUBSCRIBER OR APPLICANT NAME (PLEASE PRINT)			SUBSCRIBER ID #	
MAILING ADDRESS			SOCIAL SECURITY #	
CITY	STATE	ZIP	COUNTY	
TELEPHONE NUMBER - HOME ()		TELEPHONE NUMBER - WORK ()		

AUTOMATIC FUNDS TRANSFER AUTHORIZATION

I have selected the monthly payment option, and I hereby authorize LifeWise Health Plan of Washington to initiate funds transfer from the bank or depository financial institution account indicated below. I authorize my financial institution to honor these transfers.

Financial Institution or Bank Name	
Account Holder's Name (print)	
City, State, ZIP	Account Number
Bank Routing Number*	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
*9-digit number at bottom of check (for checking account) or deposit slip (for savings account).	
<p>Additional Terms and Conditions:</p> <ul style="list-style-type: none"> ➤ Funds are to be transferred on the 1st business day of each month or as soon thereafter as practical, paying for that month's coverage. (For example: The deduction on December 1st pays for coverage in December.) ➤ If the automatic withdrawal date falls on a weekend or holiday, your deduction will be taken on the next business day. ➤ I understand that this Automatic Funds Transfer Authorization (AFT) will remain in effect until LifeWise has received notice from me that it should be cancelled. To ensure prompt cancellation of my Automatic Funds Transfer, this notice must be submitted at least 20 days prior to my next scheduled transfer. I have the right to stop payment of a specific transfer from my depository financial institution at least 3 days before the next scheduled withdrawal date. ➤ It may take as long as 45 days to setup an AFT. You may receive an invoice to cover the initial month/s. ➤ Subscription charges for this contract cannot be paid or sponsored by an employer. <p>Please enclose voided check (for checking account) or a deposit slip (for savings account) from the account TO BE DEDUCTED.</p>	
Account Holder's Signature: X _____	Date (MM/DD/YYYY): _____

BEFORE MAILING, PLEASE BE SURE THAT YOU:

1. **Attach** a deposit slip from your savings account or a voided check from your checking account.
2. **Check** with your bank to ensure that they will accept automatic withdrawals.
3. **Keep** a copy of this form for your files and return the original.